1940 EATING DISORDER 'PANDEMIC'

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Objectives Children and young people (CYP) admitted with eating disorders (ED) during COVID19 increased dramatically, by 69%, from 2019–2021 according to NHS England.[1] This was reflected in Belfast on our general paediatric ward.

This project aimed to improve multidisciplinary team (MDT) communication and knowledge in the management of CYP using Junior Marsipan guidelines (JMG)[2] and the subsequent Medical Emergencies in Eating Disorders guidelines (MEED).[3] Secondary aims included educating healthcare staff regarding admission criteria, improving acute medical management of ED and providing patient centred care.

Methods An MDT admission care pathway and triage card were designed with contribution from paediatric medical and nursing staff, dietetics and CAMHS Eating Disorder Youth Service. The triage card and care pathway aimed to identify high risk CYP with suspected ED and guide medical staff regarding admission. The pathway directs history taking, investigations, medical management, potential complications, meal plans and CAMHS review. The eating disorder triage card was launched in May 2021 and admission care pathway in November 2021 in the Ulster Hospital.

We assessed staff confidence levels managing CYP with ED prior to the intervention in November 2021, using an online anonymised questionnaire. This evaluated staff knowledge, confidence and patient care provision. Respondents included consultants, registrars, SHOs and nurses.

A subsequent PDSA cycle in July 2022 involved review of the 2022 MEED Guidelines,[3] incorporating these into the admission care pathway. A key change was the updated risk assessment framework.

Results The initial questionnaire showed that 100% of respondents observed an increase in the number of ED patients encountered in their practice compared with pre Covid. 33% of respondents felt confident managing ED, 39% equivocal and 28% did not feel confident. Only 33% felt confident applying JMG when managing these CYP. Current MDT communication was deemed poor/very poor by 66.7% and 94% felt introduction of a care pathway would help management of children and young people with ED and MDT communication.

Conclusions CYP with ED are a challenging patient group and management requires an MDT approach. This project has improved MDT management/communication of CYP with ED on general paediatric wards. We are currently undertaking a questionnaire to assess staff feedback following introduction of the triage card and admission care pathway.

Our next step is to develop a regional eating disorder admission care pathway for use throughout NI. We plan to introduce an information leaflet for parents of CYP admitted for medical management of eating disorders and to collaborate further with the CAMHS ED service to streamline the referral process.

REFERENCES

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2. Junior Marsipan guidelines, RCPSYCH, January 2012 (accessed 30th December 2020)
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1942 HOW CAN WE IMPROVE THE SERVICES WE DELIVER TO CYP EXPERIENCING A MENTAL HEALTH CRISIS?

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Objectives To evaluate the service provided by an Acute Children's Hospital for patients admitted with mental health issues during the first wave of Covid-19.

Methods Data was collated on patients admitted with mental health-related complaints between 1st March 2020 and 31st May 2020. This included 'intoxication'; 'overdose'; 'psychosis'; 'self-harm'; 'suicidal ideation/attempt'; 'CAMHS', 'disordered/reduced eating/anorexia'; 'mental health'; 'anxiety'; 'unwell'. Only patients admitted via Children's Accident & Emergency Department were included. Current inpatients, and those attending with injuries were excluded.

The following parameters were evaluated: presenting complaint; age; length of hospital stay; time medically fit for discharge (MFFD); time to see mental health professional (MHP); time MFFD to discharge; nursing ratio; number of readmissions; episodes of restraint; absconsions; and safeguarding referrals during admission.

Results 72 mental health-related admissions were identified. The mean age at presentation was 14.8years, with modal age 16years(33%). 10%(n=7) of these were admitted for disordered eating, while 90% were admitted for a range of mental health diagnoses. The modal presenting complaint was overdose(n=20), of which paracetamol(70%, n=19) was the most common substance.

The average length of stay was 59hours. 62%(n=42) patients were MFFD at time of admission, whilst a further 16%(n=11) were MFFD within 6 hours of admission. The mean time to see a MHP was 21hours with a modal time of within 24hours(42%, n=22), which correlates with the modal time from MFFD to time of discharge(n=24 within 24hours).

During the period of analysis, 10 patients(14%) were readmitted, of which 80% were readmitted twice, and 60% within 48hours of discharge. 18%(n=13) patients required 1:1 or 2:1 care, and a further 4 patients(6%) required hourly observations. Of those requiring 1:1 care, a resident parent/carer provided this in 18% of cases and RMN staff in 36% cases, whilst nursing staff made up 45% of the support. When 2:1 support was required, this always required a member of the nursing team to be re-allocated.

14%(n=10) of patients required physical restraint, which always involved the security team, and involved police in a third of cases, whilst chemical restraint by sedation was required in 10%(n=7). During admission to the ward as a 'place of safety', 3% patients attempted strangulation, and 3% took an overdose during their stay. 14%(n=10) patients absconded or attempted to abscond from the ward and 15% (n=11) patients triggered a safeguarding referral as a result of admission.

Conclusions This study highlights the resource burden of mental health(MH) inpatients – burden on nurse staffing, use of security team for physical restraint and use of chemical